		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026286

Facility Name: Holy Family Health Center

Address: 2380 East Dempster (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: (847) 296-3335 **Fax #** (847) 296-2027

IDPA ID Number: 363121158001

Date of Initial License for Current Owners: 05/01/1981

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,332	1
2		Skilled Pediatric (SNF/PED)			2
3	235	Intermediate (ICF)	235	86,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	337	TOTALS	337	123,342	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,184	7,688	9,313	24,185	8
9	SNF/PED					9
10	ICF	21,181	15,699		36,880	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,365	23,387	9,313	61,065	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.51%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 9,313

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary		1,760		1,760		1,760		1,760			1
2	Food Purchase		936,626		936,626		936,626	(2,722)	933,904			2
3	Housekeeping	310,683	41,836	10,268	362,787		362,787		362,787			3
4	Laundry	174,574	46,661		221,235		221,235	(32,669)	188,566			4
5	Heat and Other Utilities			261,756	261,756		261,756		261,756			5
6	Maintenance	127,954	18,784	74,596	221,334		221,334	(5,551)	215,783			6
7	Other (specify):* Security Services	25,039			25,039		25,039		25,039			7
8	**TOTAL General Services**	638,250	1,045,667	346,620	2,030,537		2,030,537	(40,942)	1,989,595			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,773,299	104,717	4,794	3,882,810		3,882,810	8,494	3,891,304			10
10a	Therapy	308,346	12,526	30,019	350,891		350,891		350,891			10a
11	Activities	178,672	3,049	3,095	184,816		184,816		184,816			11
12	Social Services	56,117		1,000	57,117		57,117		57,117			12
13	Nurse Aide Training											13
14	Program Transportation			162	162		162		162			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,316,434	120,292	57,070	4,493,796		4,493,796	8,494	4,502,290			16
	C. General Administration											
17	Administrative	111,240		895,826	1,007,066		1,007,066	(895,826)	111,240			17
18	Directors Fees											18
19	Professional Services			3,330	3,330		3,330	(3,330)				19
20	Dues, Fees, Subscriptions & Promotions			6,437	6,437		6,437		6,437			20
21	Clerical & General Office Expenses	103,355	16,371	24,212	143,938		143,938	499,186	643,124			21
22	Employee Benefits & Payroll Taxes			1,616,878	1,616,878		1,616,878	55,955	1,672,833			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,522	4,522		4,522		4,522			24
25	Other Admin. Staff Transportation			10,857	10,857		10,857		10,857			25
26	Insurance-Prop.Liab.Malpractice			166,501	166,501		166,501		166,501			26
27	Other (specify):*											27
28	**TOTAL General Administration**	214,595	16,371	2,728,563	2,959,529		2,959,529	(344,015)	2,615,514			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,169,279	1,182,330	3,132,253	9,483,862		9,483,862	(376,463)	9,107,399			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Holy Family Health Center #0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			406,631	406,631		406,631	66,442	473,073			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			237,320	237,320		237,320	(51,863)	185,457			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,299	37,299		37,299		37,299			35
36	Other (specify):*											36
37	**TOTAL Ownership**			681,250	681,250		681,250	14,579	695,829			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		922,608	24,411	947,019		947,019		947,019			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,014	185,014		185,014		185,014			42
43	Other (specify):* Nonallowable Costs			4,479	4,479		4,479	(4,479)				43
44	**TOTAL Special Cost Centers**		922,608	213,904	1,136,512		1,136,512	(4,479)	1,132,033			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,169,279	2,104,938	4,027,407	11,301,624		11,301,624	(366,363)	10,935,261			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,722)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(32,669)	4		8
9	Non-Straightline Depreciation	69	30		9
10	Interest and Other Investment Income	(51,863)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(20,317)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (107,502)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(258,861)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (258,861)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (366,363)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Holy Family Health Center

ID# 0026286

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expense	$ (1,000)	43	1
2	Marketing Expense	(30)	43	2
3	Offset maintenance income from convent	(74)	43	3
4	Offset maintenance income from convent	(573)	43	4
5	Offset maintenance income from convent	(136)	43	5
6	Offset maintenance income from convent	(933)	43	6
7	Offset maintenance income from convent	(1,036)	43	7
8	Offset maintenance income from convent	(206)	43	8
9	Offset maintenance income from convent	(166)	43	9
10	Offset maintenance income from convent	(325)	43	10
11	Offset maintenance income from convent	(5,551)	6	11
12	Disallow collection fees in legal	(3,330)	19	12
13	Offset miscellaneous income	(6,957)	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,317)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center
Provider #: 0026286
07/01/2003 to 06/30/2004 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Health Center **#** 0026286 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,722)	0	0	0	0	0	0	0	0	0	0	(2,722)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(32,669)	0	0	0	0	0	0	0	0	0	0	(32,669)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(5,551)	0	0	0	0	0	0	0	0	0	0	(5,551)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(40,942)	0	0	0	0	0	0	0	0	0	0	(40,942)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	8,494	0	0	0	0	0	0	0	0	0	8,494	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	8,494	0	0	0	0	0	0	0	0	0	8,494	16
	C. General Administration													
17	Administrative	0	(895,826)	0	0	0	0	0	0	0	0	0	(895,826)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,330)	0	0	0	0	0	0	0	0	0	0	(3,330)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(6,957)	506,143	0	0	0	0	0	0	0	0	0	499,186	21
22	Employee Benefits & Payroll Taxes	0	55,955	0	0	0	0	0	0	0	0	0	55,955	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,287)	(333,728)	0	0	0	0	0	0	0	0	0	(344,015)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,229)	(325,234)	0	0	0	0	0	0	0	0	0	(376,463)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Health Center # 0026286 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	69	66,373	0	0	0	0	0	0	0	0	0	66,442	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,863)	0	0	0	0	0	0	0	0	0	0	(51,863)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(51,794)	66,373	0	0	0	0	0	0	0	0	0	14,579	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,479)	0	0	0	0	0	0	0	0	0	0	(4,479)	43
44	**TOTAL Special Cost Centers**	(4,479)	0	0	0	0	0	0	0	0	0	0	(4,479)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(107,502)	(258,861)	0	0	0	0	0	0	0	0	0	(366,363)	45

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See attached list				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing supplies	$	Resurrection Health Care	100.00%	$ 8,494	$ 8,494	1
2	V	21	Clerical & data processing svcs		Resurrection Health Care	100.00%	244,754	244,754	2
3	V	21	8494		Resurrection Health Care	100.00%	261,389	261,389	3
4	V	22	Employee benefits		Resurrection Health Care	100.00%	55,955	55,955	4
5	V	30	Depreciation		Resurrection Health Care	100.00%	66,373	66,373	5
6	V	17	Management Fee	895,826	Resurrection Health Care	100.00%		(895,826)	6
7	V	39	Intercompany pharmacy	922,608			922,608		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,818,434			$ 1,559,573	$ * (258,861)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See attached pg 7A										2
3											3
4											4
5											5
6											6
7											7
8	Sister Elizabeth Tremczynski	Director	Board of Directors	0.00				Administrator	111,240	17 (1)	8
9	*Sister Elizabeth is also listed on the attached Board of Directors listing.										9
10											10
11											11
12											12
13								TOTAL	$ 111,240		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Ctr
Street Address: 7435 W. Talcott Ave.
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing supplies				$	$		$ 8,494	1
2	21	Clerical & data processing svcs.							244,754	2
3	21	Other Administrative services							261,389	3
4	22	Employee benefits							55,955	4
5	30	Depreciation							66,373	5
6	39	Pharmacy							922,608	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,559,573	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	National City		x	Mortgage	$38,313.00	11/10/94	$ 5,623,000	$ 3,452,424	11/04	0.0653	$ 237,320	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related				$38,313.00		$ 5,623,000	$ 3,452,424			$ 237,320	9
	B. Non-Facility Related*											
10	Interest Income Offset								Offset interest income		(51,863)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (51,863)	14
15	TOTALS (line 9+line14)						$ 5,623,000	$ 3,452,424			$ 185,457	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003	N/A	12

Facility is a not-for-profit entity and does not pay real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Health Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026286

CONTACT PERSON REGARDING THIS REPORT Lou Fragoso

TELEPHONE (773)594-8556 FAX #: (773)594-8567

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 136,250 B. General Construction Type: Exterior Face Brick Frame Steel Number of Stories 6

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use		1981	$ 610,897	1
2	Business Use		1984-2000	312,530	2
3	TOTALS			$ 923,427	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	337		1981	1963	$ 5,610,288	$ 153,162	26	$ 153,162	$	$ 5,411,920	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1981	39,944	288	various	288		39,436	9
10	Land Improvements			1982	3,300		15			3,300	10
11	Land Improvements			1983	16,546		15			16,546	11
12	Land Improvements			1985	2,758		15			2,758	12
13	Land Improvements			1987	26,060		10			26,060	13
14	Land Improvements			1991	2,934		8			2,934	14
15	Land Improvements: Repaving Dempster lo			1996	6,944	694	10	694		5,553	15
16	Land Improvements: Utility pole			1996	1,908	127	15	127		1,017	16
17	Building Improvements			1981	30,116	1,503	various	1,503		26,136	17
18	Building Improvements			1982	38,889	211	20	211		38,889	18
19	Building Improvements			1983	137,540	686	various	686		105,502	19
20	Building Improvements			1984	161,928	8,084	various	8,084		131,395	20
21	Building Improvements			1985	140,002		various			140,002	21
22	Building Improvements			1986	74,495	1,510	15	1,510		67,662	22
23	Building Improvements			1987	81,758	1,273	various	1,273		81,758	23
24	Building Improvements			1988	9,477	622	various	622		9,477	24
25	Building Improvements			1989	29,180	1,962	various	1,962		29,180	25
26	Building Improvements			1990	119,639	10,442	various	10,442		119,639	26
27	Building Improvements			1991	209,393	12,221	various	12,221		183,027	27
28	Building Improvements			1992	47,000	1,625	10	1,625		47,000	28
29	Building Improvements			1992	79,513	6,097	various	6,097		73,168	29
30	Building Improvements			1993	55,142	3,941	various	3,941		43,352	30
31	Building Improvements			1993	7,044	470	15	470		5,168	31
32	Building Improvements			1994	86,489	7,515	various	7,515		75,149	32
33	Building Improvements: #20-4			1995	5,035	458	11	458		4,121	33
34	Building Improvements: #20-5			1995	5,469		5			5,469	34
35	Building Improvements: #20-5			1995	7,988	726	11	726		7,867	35
36	Building Improvements: #20-5			1995	3,648	365	10	365		3,284	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvement #21-4	1995	$ 94,827	$ 8,621	11	$ 8,621	$	$ 77,588	37
38	Building Improvement #21-5	1995	34,922	3,175	11	3,175		28,574	38
39	Building Improvement #21-5	1995	1,423	142	10	142		1,279	39
40	Building Improvement #26-4	1995	6,906	460	15	460		4,141	40
41	Building Improvement #26-5	1995	6,358	424	15	424		3,816	41
42	Building Improvements: Carpeting for facility	1996	43,550		5			43,550	42
43	Building Improvements: Rudd water heater tank	1996	825	83	10	83		663	43
44	Building Improvements:Rekey/Lock/Latches	1996	13,413	894	15	894		7,152	44
45	Building Improvements:Upgrade East elevator	1996	35,024	1,751	20	1,751		14,009	45
46	Building Improvements:Wall covering in dining room	1996	7,240		5			7,240	46
47	Building Improvements:Phone system and call system	1996	44,556	4,456	10	4,456		35,648	47
48	Building Improvements:Remodeling 3rd floor patient rooms	1996	316,547	21,103	15	21,103		168,825	48
49	Building Improvements:Tiling of shower room	1996	1,355	68	20	68		544	49
50	Building Improvements:Cabinets and shower doors	1996	15,698	785	20	785		6,280	50
51	Double face exterior sign	1997	5,174	517	10	517		3,620	51
52	Refurbish 2404 sign(Business Office)	1997	2,428	243	10	243		1,700	52
53	Sealcoating parking lot area	1997	3,804	380	10	380		2,660	53
54	Painting,wallcovering,tile replacement of nursing station	1997	102,440	6,829	15	6,829		47,804	54
55	Heaters convector	1997	3,240	324	10	324		2,268	55
56	Emergency phones in elevators - West	1997	1,264	126	10	126		882	56
57	Air Dampers - East Building	1997	2,099	210	10	210		1,470	57
58	Boilers for East Building	1997	4,310	287	15	287		2,010	58
59	Carpeting Room 215	1997	650	14	5	14		650	59
60	Air Handler of West Building	1997	1,450	145	10	145		978	60
61	Painting,wallcovering, floor replacement of 2 West station	1998	34,662	2,311	15	2,311		13,866	61
62	Painting,wallcovering, floor replacement of 4 West station	1998	77,327	5,155	15	5,155		30,931	62
63	Painting,wallcovering, floor replacement of 5 West station	1998	76,450	5,097	15	5,097		30,582	63
64	30 Ton Chiller	1998	17,670	1,178	15	1,178		7,688	64
65	Fire Dampers in bath rooms	1998	7,135	476	15	476		2,856	65
66	Repair water main from Department 300	1998	3,887	389	10	389		2,333	66
67	Gutter replacement of East Building	1999	6,400	640	10	640		3,200	67
68	Painting,wallcovering, floor replacement of 2 East station	1999	62,793	4,186	15	4,186		20,930	68
69	Replacement of Tran Compressor	1999	7,063	471	15	471		2,352	69
70	TOTAL (lines 4 thru 69)		$ 8,083,317	$ 284,922		$ 284,922	$	$ 7,284,858	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,083,317	$ 284,922		$ 284,922	$	$ 7,284,858	1
2	Call system upgrade 1 West	1999	33,238	3,324	10	3,324		16,620	2
3	Call system upgrade 3 West	1999	17,274	1,727	10	1,727		8,638	3
4	Painting,wallcovering,floor replacement of 4 West station	1999	2,082	139	15	139		692	4
5	Painting,wallcovering,floor replacement of Physical Therapy	1999	8,665	578	15	578		2,890	5
6	Construction of Parking Lot	2000	227,278	11,364	20	11,364		45,456	6
7	Landscaping	2000	7,208	721	10	721		2,883	7
8	Replace East elevator hydrolift	2000	33,472	2,231	15	2,231		8,926	8
9	Repair decking	2000	7,000	467	15	467		1,867	9
10	Door replacement	2000	3,035	304	10	304		1,216	10
11	Construction of Parking Lot	2001	15,451	813	19	813		2,440	11
12	2380 Building remodeling	2001	6,985	699	10	699		1,748	12
13	Freight elevator gate	2001	1,300	87	15	87		260	13
14	Door replacement	2001	3,378	282	12	282		846	14
15	Gas Steamer - connection with Booster	2001	7,507	500	15	500		1,500	15
16	Water Main Repair	2002	8,109	405	20	405		911	16
17	Building, Reception and office improvements	2002	199,513	13,301	15	13,301		29,927	17
18	Installation of new WEIL Pump	2002	3,438	688	5	688		1,548	18
19	Repair Flat Roof to Wood Deck	2002	9,445	945	10	945		2,126	19
20	Telephone cables	2002	16,900	1,690	10	1,690		3,803	20
21	Topograpic Mapping of entire facility	2002	8,316	554	15	554		1,247	21
22									22
23	7 new signs	2002	7,744	774	10	774		1,161	23
24	1 new sign	2003	5,487	549	10	549		823	24
25	Norstar digital trunk cartridge, DTI/PRI assy.	2003	5,425	1,085	5	1,085		1,628	25
26	Programming - Direct TV	2003	15,000	3,000	5	3,000		4,500	26
27	Electrical equipment and labor	2002	24,029	1,602	15	1,602		2,403	27
28	Exterior & interior renov-From 3/30/02 to 4/26/02	2002	10,381	692	15	692		1,038	28
29	Install bumper/crash	2002	15,049	1,505	10	1,505		2,257	29
30	New circuit in basement	2002	6,155	410	15	410		615	30
31	Kronos clock - replace jack,install jack cord	2002	265	18	15	18		27	31
32	New door locks	2002	8,575	572	15	572		858	32
33	Overhead paging system	2002	2,500	250	10	250		375	33
34	TOTAL (lines 1 thru 33)		$ 8,803,521	$ 336,198		$ 336,198	$	$ 7,436,087	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,803,521	$ 336,198		$ 336,198	$	$ 7,436,087	1
2	Accounting Dept relocating to Des Plaines	2002	1,613	108	15	108		162	2
3	Disconnect furn. Re-wire at Holy Family-Des Pl.	2002	2,995	300	10	300		450	3
4	Wrought iron pipe rail	2003	1,820	91	20	91		137	4
5	Install raceways for voice data lines	2003	770	77	10	77		116	5
6	Basement office - data and voice cabling	2003	2,755	184	15	184		276	6
7	Redesign and contructions-1st fl. Office space	2002	127,916	3,280	39	3,280		4,920	7
8	Architech fees for exterior & interior renovation	2003	14,810	987	15	987		1,481	8
9	Sign	2003	10,000	1,000	10	1,000		1,500	9
10									10
11	Repair catch basin on North parking lot	2003	850	43	10	43		43	11
12	Install new 6" storm line from bldg to new inl	2003	8,614	431	10	431		431	12
13	Parking Patch project # 50950-04	2004	1,523	51	15	51		51	13
14	Data Cable for Res Info/Rooms 120 & 135	2004	1,041	35	5	104	69	104	14
15	Building renovation	2004	4,333	108	20	108		108	15
16	Res-info-ancillary bldg dev.	2004	1,444	103	7	103		103	16
17	HF/Res info-remove/relocate 2 voice & data	2004	450	32	7	32		32	17
18	Work performed - 2nd floor, room 203	2004	1,191	60	10	60		60	18
19	Landscaping design	2004	2,709	54	25	54		54	19
20	Exterior & interior renovation - SD	2004	25,856	862	15	862		862	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Management allocation					66,373	66,373		32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,014,211	$ 344,004		$ 410,446	$ 66,442	$ 7,446,977	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,511,263	$ 57,124	$ 57,124	$	5-15	$ 1,170,982	71
72	Current Year Purchases	77,539	3,627	3,627		5-15	3,627	72
73	Fully Depreciated Assets	825,058					825,058	73
74								74
75	TOTALS	$ 2,413,860	$ 60,751	$ 60,751	$		$ 1,999,667	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1987 Ford Van	1992	$ 5,000	$	$	$	5	$ 5,000	76
77	Maintenance	1992 Ford F250	1992	18,860				5	18,860	77
78	Facility	1998 Saturn Wagon	1997	10,891				5	10,891	78
79	See attached schedule Sch. 13A			68,838	1,876	1,876		4	68,838	79
80	TOTALS			$ 103,589	$ 1,876	$ 1,876	$		$ 103,589	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,455,087	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 406,631	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 473,073	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 66,442	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,550,233	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Holy Family Health Center
Provider # 0026286
7/1/2003 - 6/30/2004

Schedule 13A

Vehicle Depreciation

Description	Model	Year	Cost	Current Bk Depr	St. Line Depr	Adjusts	Life in Years	Accum Depr	Line Reference
Resident	Dodge Caravan SS w/resident T-wheel chair	1998	38,811				4	38,811	79
Facility	Dodge 10 Passenger Van	1999	30,027	1,876	1,876		4	30,027	79
Total			68,838	1,876	1,876			68,838	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 37,299 Description: See attached schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center
Provider #: 0026286
07/01/2003 to 06/30/2004

Schedule 14A

Supplemental Schedule of Equipment Rental

Description	Amount
Copiers	5,131
Oxygen tanks	4,219
Postage machine	2,855
Nursing Equipment	1,501
IV pumps	15,765
Wound Vacuum Machine	2,017
Therapeutic Unit	1,600
Maintenance Equipment	2,851
Ultrasound Equipment	565
Other Office Equipment	795
Total Equipment Rental	37,299

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A (1,2,3)	3626 hrs	$ 104,245	571	$ 8,557	$ 166	4,197	$ 112,968	1
2	Licensed Speech and Language Development Therapist	10A (2,3)	hrs		1,127	16,911	263	1,127	17,174	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1,2,3)	7099 hrs	204,101	303	4,551	1,555	7,402	210,207	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 (2)	# of prescrpts				922,608		922,608	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached sch16A					24,411	10,542		34,953	13
14	TOTAL			$ 308,346	2,001	$ 54,430	$ 935,134	12,726	$ 1,297,910	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center
Provider #: 0026286
07/01/2003 to 06/30/2004 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Respiratory Therapy	10A (2)			10,542
Laboratory	39 (3)		23,933	
Radiology	39 (3)		478	
			24,411	10,542

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,018,393	$ 1,018,393	1
2	Cash-Patient Deposits	94,704	94,704	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,383,350)	1,652,804	1,652,804	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	92,427	92,427	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,858,328	$ 2,858,328	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	923,427	923,427	13
14	Buildings, at Historical Cost	5,393,606	5,610,288	14
15	Leasehold Improvements, at Historical Cost	386,022	3,403,923	15
16	Equipment, at Historical Cost	5,752,002	2,517,449	16
17	Accumulated Depreciation (book methods)	(9,550,233)	(9,550,233)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,904,824	$ 2,904,854	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,763,152	$ 5,763,182	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 114,527	$ 114,527	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,139	30,139	28
29	Short-Term Notes Payable	202,100	202,100	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany payable	2,089,913	2,089,913	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,436,679	$ 2,436,679	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,250,324	3,250,324	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Related party notes	5,326,549	5,326,549	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,576,873	$ 8,576,873	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,013,552	$ 11,013,552	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,250,400)	$ (5,250,370)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,763,152	$ 5,763,182	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,509,319)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,509,319)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(741,081)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (741,081)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,250,400)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,334,665	1
2	Discounts and Allowances for all Levels	(4,648,718)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,685,947	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,288,416	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,288,416	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,076	13
14	Non-Patient Meals	2,722	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	21,600	16
17	Sale of Drugs	1,110,260	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,452	19
20	Radiology and X-Ray	2,860	20
21	Other Medical Services	110,341	21
22	Laundry	32,669	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,309,980	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	51,863	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,863	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc Income See attached Sch 19A**	15,957	28
28a	**Intrarelated rental income**	208,380	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 224,337	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,560,543	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,030,537	31
32	Health Care	4,493,796	32
33	General Administration	2,959,529	33
	B. Capital Expense		
34	Ownership	681,250	34
	C. Ancillary Expense		
35	Special Cost Centers	951,498	35
36	Provider Participation Fee	185,014	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,301,624	40
41	**Income before Income Taxes (line 30 minus line 40)****	(741,081)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (741,081)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Holy Family Health Center
Provider #0026286
07/01/2003 - 06/30/2004

Schedule 19A

Supplemental Schedule of Revenues

Description	Amount
Convent Maintenance Payments	9,000
Miscellaneous	6,957
	15,957

See Accountants' Compilation Report

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,840	2,133	$ 80,358	$ 37.67	1
2	Assistant Director of Nursing	460	480	14,063	29.30	2
3	Registered Nurses	51,699	57,868	1,680,730	29.04	3
4	Licensed Practical Nurses	5,751	6,556	140,341	21.41	4
5	Nurse Aides & Orderlies	113,038	126,212	1,669,780	13.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,652	10,724	308,346	28.75	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,774	14,023	178,672	12.74	10
11	Social Service Workers	3,712	4,051	56,117	13.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,967	6,340	127,954	20.18	17
18	Housekeepers	27,706	30,637	310,683	10.14	18
19	Laundry	14,981	16,888	174,574	10.34	19
20	Administrator	2,000	2,080	111,240	53.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,720	8,391	103,355	12.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,900	3,049	47,924	15.72	31
32	Other Health Ca See Sch 20A	6,578	7,386	140,103	18.97	32
33	Other(specify) Security	1,517	2,108	25,039	11.88	33
34	TOTAL (lines 1 - 33)	268,295	298,926	$ 5,169,279 *	$ 17.29	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	9 (3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	11	446	11 (3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	11	$ 18,446		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	92	$ 3,899	10 (3)	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	92	$ 3,899		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Holy Family Health Center
Provider #: 0026286
07/01/2003 to 06/30/2004 **Schedule 20A**

XVIII. A. Staffing & Salary Costs

Line 32 Other Health Care :

Description	Hours Worked	Hours Paid	Total Wages	Average Hourly Wage
Care Plan Coordinator	3,650	4,134	105,045	25.41
Unit Receptionist	2,928	3,252	35,058	10.78
Total	6,578	7,386	140,103	18.97

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sr. Elizabeth Tremczynski	Administrator	0	$ 111,240
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 111,240

B. Administrative - Other

Description	Amount
Management company	$ 895,826
(Total adjusted out in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 895,826
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Grabowski & Greene	Legal	$ 3,330
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,330

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,178
Unemployment Compensation Insurance	13,291
FICA Taxes	380,430
Employee Health Insurance	860,798
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Fund	244,610
Group Life, disability, vision,dental	70,380
Employee assistance (SAP)	3,429
Tuition reimbursement	5,462
Other benefit	439
Pre-employment mentoring	5,861
Management allocation	55,955
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,672,833

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	4,615
Other dues & subscriptions	1,822
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,437

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	4,522
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,522

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center
Provider #: 0026286
07/01/2003 to 06/30/2004 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	3,330
Disallowed collection fees	(3,330)
Total (agree to Schedule V, line 19, column 8)	0

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4								N/A					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $4,615**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **13,420** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **185,014**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **2,722**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **1 %**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		0	1,760	0	1,760	0	1,760	0	1,760
2. Food Purchase		0	936,626	0	936,626	0	936,626	-2,722	933,904
3. Housekeeping		310,683	41,836	10,268	362,787	0	362,787	0	362,787
4. Laundry		174,574	46,661	0	221,235	0	221,235	-32,669	188,566
5. Heat and Other Utilities		0	0	261,756	261,756	0	261,756	0	261,756
6. Maintenance		127,954	18,784	74,596	221,334	0	221,334	-5,551	215,783
7. Other (specify)*		25,039	0	0	25,039	0	25,039	0	25,039
8. Total General Services		638,250	1,045,667	346,620	2,030,537	0	2,030,537	-40,942	1,989,595
9. Medical Director		0	0	18,000	18,000	0	18,000	0	18,000
10. Nursing & Medical Records		3,773,299	104,717	4,794	3,882,810	0	3,882,810	8,494	3,891,304
10a. Therapy		308,346	12,526	30,019	350,891	0	350,891	0	350,891
11. Activities		178,672	3,049	3,095	184,816	0	184,816	0	184,816
12. Social Services		56,117	0	1,000	57,117	0	57,117	0	57,117
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	162	162	0	162	0	162
15. Other (specify)*		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		4,316,434	120,292	57,070	4,493,796	0	4,493,796	8,494	4,502,290
17. Administrative		111,240	0	895,826	1,007,066	0	1,007,066	-895,826	111,240
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	3,330	3,330	0	3,330	-3,330	0
20. Fees, Subscriptions & Promotion		0	0	6,437	6,437	0	6,437	0	6,437
21. Clerical & General Office		103,355	16,371	24,212	143,938	0	143,938	499,186	643,124
22. Employee Benefits & Payroll		0	0	1,616,878	1,616,878	0	1,616,878	55,955	1,672,833
23. Inservice Training & Education		0	0	0	0	0	0	0	0
24. Travel and Seminar		0	0	4,522	4,522	0	4,522	0	4,522
25. Other Admin. Staff Trans		0	0	10,857	10,857	0	10,857	0	10,857
26. Insurance-Prop.Liab.Malpractice		0	0	166,501	166,501	0	166,501	0	166,501
27. Other (specify)*		0	0	0	0	0	0	0	0
28. Total General Adminis		214,595	16,371	2,728,563	2,959,529	0	2,959,529	-344,015	2,615,514
29. Total General Administrative		5,169,279	1,182,330	3,132,253	9,483,862	0	9,483,862	-376,463	9,107,399
30. Depreciation		0	0	406,631	406,631	0	406,631	66,442	473,073
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	237,320	237,320	0	237,320	-51,863	185,457
33. Real Estate		0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds		0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles		0	0	37,299	37,299	0	37,299	0	37,299
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	681,250	681,250	0	681,250	14,579	695,829
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	922,608	24,411	947,019	0	947,019	0	947,019
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	185,014	185,014	0	185,014	0	185,014
43. Other (specify):*		0	0	4,479	4,479	0	4,479	-4,479	0
44. Total Special Cost Ce		0	922,608	213,904	1,136,512	0	1,136,512	-4,479	1,132,033
45. Grand Total		5,169,279	2,104,938	4,027,407	11,301,624	0	11,301,624	-366,363	10,935,261

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,018,393	1,018,393
2. Cash - Patient Deposits	94,704	94,704
3. Accounts & Notes Recievable	1,652,804	1,652,804
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	92,427	92,427
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,858,328	2,858,328
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	923,427	923,427
14. Buildings, at Historical Cost	5,393,606	5,610,288
15. Leasehold Improvements, Historical Cost	386,022	3,403,923
16. Equipment, at Historical Cost	5,752,002	2,517,449
17. Accumulated Depreciation (book methods)	-9,550,233	-9,550,233
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	2,904,824	2,904,854
25. Total Assets	5,763,152	5,763,182
CURRENT LIABILITIES		
26. Accounts Payable	114,527	114,527
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	30,139	30,139
29. Short-Term Notes Payable	202,100	202,100
30. Accrued Salaries Payable	0	0
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,089,913	2,089,913
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,436,679	2,436,679
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	3,250,324	3,250,324
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	5,326,549	5,326,549
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	8,576,873	8,576,873
46.Total Liabilities	########	11,013,552
47.Total Equity	-5,250,400	-5,250,370
48.Total Liabilities and Equity	5,763,152	5,763,182

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,334,665
2. Discounts and Allowances for all Levels	-4,648,718
Subtotal - Inpatient Care	6,685,947
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	2,288,416
7. Oxygen	0
Subtotal - Anciliary Revenue	2,288,416
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	1,076
14. Non-Patient Meals	2,722
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	21,600
17. Sale of Drugs	1,110,260
18. Sale of Supplies to Non-Patients	0
19. Laboratory	28,452
20. Radiologyand X-Ray	2,860
21. Other Medical Services	110,341
22. Laundry	32,669
Subtotal - Other Operating Revenue	1,309,980
24. Contributions	0
25. Interest and Other Investments Income	51,863
Subtotal - Non-Operating Revenue	51,863
27. Other Revenue (specify):	0
28. Other Revenue (specify):	224,337
Subtotal - Other Revenue	224,337
30. Total Revenue	10,560,543
31. General Services	2,030,537
32. Health Care	4,493,796
33. General Administration	2,959,529
34. Ownership	681,250
35. Special Cost Centers	951,498
35. Provider Participation Fee	185,014
37. Other	0
40. Total Expenses	11,301,624
41. Income Before Income Taxes	-741,081
42. Income Taxes	0
43. Net Income or Loss for the Year	-741,081

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